State Innovation Models:
Round Two of Funding for Design and Test Assistance
Funding Opportunity Number: CMS-1G1-14-001
Budget Negotiation – 2nd Tier Programmatic Questions

State	Connecticut
Applicant	Office of the Healthcare Advocate
Application #	1G12014000289
Type of Award Sought	Model Test
Amount Requested	Federal: $63,725,086

We have conducted a thorough programmatic review of your answers to the first tier of budget negotiation questions and other supplemental documents submitted. Below are additional questions/points of clarification to be addressed in your presentation session with CMS. You do not need to resubmit any other parts of your application at this time.

1) Please describe the "annual insurance assessment" process, referenced in your response to Question 1(a), sent on August 28, 2014.

Response: Connecticut's methodology is based on an assessment/apportionment on the CT Domestic Insurance Industry that writes Direct Written Premiums in CT only (CT Business only). Annually, the Connecticut Insurance Department (CID) requests premium tax liability information from the Department of Revenue Services from the previous calendar year. (Premium tax liability info is a company's Direct Written Premium times the premium tax of 1.75% which equals their premium tax liability that the CID receives). Each company's portion is related to their individual proportion to the industry total (the sum of all the assessed company's individual premium tax liability amounts. There are approximately 100 CT Domestic companies that are assessed.)

The total dollar amounts that are subject to Assessments are the total appropriated budgets of the CT Insurance Department and the Office of The HealthCare Advocate – Salaries, Fringes, Other Expenses, Equipment and Overhead, and Parts of these other State Agencies – OPM, Aging and DMHAS. Monies collected from the Assessments are deposited into a separate, non-lapsing fund called the Insurance Fund. 100% of the expenditures of the CID and OHA—and beginning this year, the SIM Program Management Office— are paid out of the Insurance Fund – with no monies / resources / funding received from the General Fund / State of CT.

The assessment is calculated during the first quarter of the fiscal year (Summer) based upon CID's and OHA's appropriations from the previous Legislative Session which ends in May/June. Any monies left in the Insurance Fund at the end of the Fiscal Year – 6/30/xx (lapses….) is credited back to the Insurance Industry on their next assessment when it is calculated (Summer).

Timing:

June / July – Assessment is calculated

August 1 - Notice of Proposed Assessment is sent to CT Domestic Insurance Companies with a 30 day look / objection period, if none are received –

September 1 is first quarterly billing of the fiscal year, followed by quarterly billings on – December 1, March 1, and June 1.

Relevant statutes can be found at C.G.S. 38a – 47 thru 52.

2) Please describe the Department's MMIS and ASO contractors' prior experience and/or readiness in assessing eligibility for, and distributing, shared savings to providers?

Response: The Department of Social Services' ("Department's) MMIS contractor (HP) and medical ASO contractor (CHN) have no prior experience in Connecticut, per se, with assessing eligibility for, and distributing, shared savings payments to providers. That said, CHN has experience in assessing eligibility for supplemental (performance) payments for the Department's Person Centered Medical Home (PCMH) initiative and for the state-funded obstetrics pay-for-performance pilot. In addition, business processes have been established under which HP has distributed these payments. In support of the QISSP, the Department proposes the following:

- Development of a shared savings methodology with its actuarial contractor, Mercer;
- Administration of a beneficiary attribution methodology by CHN that is the same as or substantially similar to the methodology currently in use for the PCMH initiative;
- Assessment of eligibility for shared savings payment by CHN; and
- Distribution of shared payments by HP using business processes similar to those employed for distribution of performance payments.

3) The state indicates that a survey of 1,200 primary care and specialist physicians is underway to assess the readiness of the physician workforce in the state to assume financial risk and provide services consistent with the advanced medical home model. When will results of this survey be available?

Response: The SIM evaluation team is preparing to launch the physician survey. As of October 1 a data collection contractor had been selected. The survey instrument is being finalized and the sample is being prepared. The survey instrument will be reviewed by the Steering Committee on October 16, pretested during the last 2 weeks of October and moved into the field the first week of November. Data collection will

continue through December with the results compiled and delivered to the State by January 15, 2015.

4) Please describe the level of success of the "lead fiduciary agent model" approach within the counties that received CDC Community Transformation Grants in Connecticut.

Response: The Lead Fiduciary Agents for the five counties awarded funding for CTG were the following local health districts:

1. Litchfield County / Torrington Health District
2. Middlesex County / Chatham Health District
3. New London County / Ledge Light Health District
4. Tolland County / Eastern Highlands Health District
5. Windham County / Northeast District Department of Health

This approach made sense since the Department of Public Health (DPH) has an on-going strong relationship with local health districts, partnering on a variety of "public health" projects in meeting the overall mission of DPH.

What further enhanced this model, is that the Lead Fiduciary Agents chosen for CTG, based on past state and/or national funding, had existing and sustainable coalitions and partnerships in their respective County to support the three CTG strategic directions mandated by CDC: 1) active living/healthy eating; 2) tobacco free living; and 3) quality clinical preventative services.

Key outcomes/points using the Lead Fiduciary Model during the three year CTG project:

1. The lead fiduciary agents:
    a. Dispersed CTG funds in their respective Counties
    b. Coordinated and submitted all fiscal, data and progress reporting for the grant cycle to DPH
2. Each County created a comprehensive Needs Assessment
3. Each County pilot tested "systems, policy and environmental change" initiatives to support the three strategic directions

Illustrative outcomes

- 16 municipalities implemented new smoke free policies (e.g. no smoking in public parks)
- Twelve schools have new healthy eating or physical activity opportunities (e.g. school gardens, class-room integrated walking initiatives, or after school programs)
- 4 out of the 5 lead fiduciary agents secured linkages with health systems serving the county and in 2 instances engaged in joint programming around self-blood pressure monitoring.

5) In the Operational Plan section of the proposal, the state indicates the Medicaid QISSP will enhance care for nearly 430,000 Medicaid beneficiaries. However, in the Financial Analysis section of your proposal, 650,000 enrollees are identified as being "directly addressed by the Medicaid Quality Improvement Shared Savings Program at an average of $390 PMPM." Please clarify.

Response: The Operational Plan refers to the number of Medicaid beneficiaries participating in the Medicaid QISSP during the period of performance. Two waves are projected to result in approximately 430,000 participants by 2018. The financial analysis extends out 10 years and thus includes a third wave (CY2020) in its projection. The third wave brings the projected total to more than 630,000 by 2020. The Operational Plan now provides a clarifying footnote with respect to the third wave on page 2.

6) Regarding the response to questions 8.a-8.c: Given the state's ability to collect these data, are the vendors employed by the state authorized to provide data to the federal evaluator? Does the state have the authority to release these data to CMS/the federal evaluator?

Response: As noted in our September 8 response to CMMI questions, the Connecticut Department of Social Services will regard disclosure of necessary records or data to the federal contractor performing evaluation of SIM to be for purposes directly connected with administration of the plan. Assuming the federal contractor has a business associate agreement with CMS, the Department will enter into data use agreements (DUA) with CMS or the federal contractor for purposes of data sharing. These DUAs will parallel those into which the Department has entered with CMS in support of data sharing for the Demonstration to Integrate Care for Medicare-Medicaid Enrollees.

With respect to commercial data, Connecticut's APCD enabling legislation does not permit the sharing of data on identifiable members to external entities such as state or federal agencies and their respective evaluators. The state will propose legislation in the 2015 legislative session that will enable the APCD to share the limited data set with the federal and state evaluation contractors for the narrow purpose of enabling

the SIM evaluation. We anticipate that such legislation can be achieved by June of 2015.

7) Regarding the response to question 8.d: Please refer to the Notice of Proposed Rule Making at the following link for guidance: (https://www.federalregister.gov/articles/2014/07/11/2014-15948/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-clinical-laboratory#h-131). If and when finalized, this rule would provide assurance that providing data in this manner would be an authorize disclosure of data under HIPAA. Only the minimum data necessary would be used to carry out the evaluation. However, CMS must be able to identify beneficiaries being touched by the model test. De-identified, aggregated data alone will be insufficient to analyze the effects of those touched by the SIM program. By statute, demonstrating cost containment and/or quality improvements is essential for model continuation, extension and expansion. Without these data, we will not be able to demonstrate these outcomes. What is the state's ability to collect and provide these Medicaid data? What is the state's contingency plan if it cannot get legislation passed to provide data from the APCD?

Response: Connecticut Medicaid has extremely strong analytic capacity and expertise. Since 2012, Connecticut Medicaid has had the benefit of a fully integrated set of claims data across all categories of Medicaid services. The Department's medical ASO, CHN, maintains this data within the Utilization & Cost Analyzer (UCA) system, an analytical and data discovery tool that includes Medicaid claims, member eligibility, and provider data. UCA utilizes QlikView software and is uploaded monthly with claims, member eligibility, and provider data directly from CHN's data warehouse specific to the Connecticut Medicaid program. The data warehouse is populated with data that is received from the Department and its claims processing partner, HP. The Department anticipates that the data extracts necessary to support the federal evaluation will be produced by CHN. As noted above, the Department will enter into data use agreements (DUA) with CMS or the federal contractor for purposes of sharing the minimum necessary identifiable data.

With respect to the APCD, if the statutory language permitting the disclosure of identifiable data from the APCD to CMMI for the purposes of SIM evaluation is not successful, the SIM PMO will work with the individual commercial payers to provide for direct submission of the minimum identifiable dataset necessary to achieve the purposes of the evaluation. We are also prepared to directly engage self-funded employers to the extent that this is necessary to ensure authorization for the provision of necessary data. The proposed HIPAA rule change appears to resolve questions that emerged in our discussions with commercial payers as to the permissibility of such disclosures under HIPAA. There are no state laws that otherwise would prohibit their disclosure, other than potential limitations on the disclosure of behavioral health information (CGS 52-14 b, c, d, e and f), which we intend to address with the above referenced changes to the APCD enabling legislation.